



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

**Requestor Name**

Richard Lawrence, MD

**Respondent Name**

New Hampshire Insurance Company

**MFDR Tracking Number**

M4-15-0403-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

September 26, 2014

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "The following bill was audited and paid incorrectly. TDI-DWC addresses Maximum Medical Improvement (MMI) Evaluations with Rule 134.204 (J) Subsection (3), Subparagraph (C). This rule states to reimburse the examining doctor, other than the treating doctor **\$350.00 for MMI evaluations**. TDI-DWC addresses Impairment Rating (IR) Evaluations with Rule 134.204, Subsection (J), Subsection (4), Subparagraph (C), (ii), (II). This rule states if a full physical evaluation, with range of motion, is performed, **reimbursement for the first musculoskeletal body area is \$300.00 and each additional musculoskeletal body area is \$150.00.**"

**Amount in Dispute:** \$150.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The carrier stands by its reduction per Rule 134.204. After further review, it has been confirmed the pricing is correct.

99456/W5.WP.RM allowing \$950.00 4 UOS

Per review:

Range of motion is performed \$300.00 for the first area treated and \$150 for each additional up to a maximum reimbursement of \$600.

The provider is billing IR upper extremity, lower extremity, back and head

\$350 (W5) + \$300 for (RM) first body area + \$150 second body area + \$150 third body area."

**Response Submitted by:** Flahive, Ogden & Latson, Post Office Drawer 201329, Austin, TX 78720

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 4, 2014	Designated Doctor Examination	\$150.00	\$150.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.204 sets out the procedures for billing and reimbursement of Designated Doctor Examinations.
3. 28 Texas Administrative Code §133.240 defines the required elements for an explanation of benefits.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - W1 – Workers Compensation State Fee Schedule Adjustment.
  - P1 – Code is not explained as required by 28 Texas Administrative Code §133.240 (f)(17)(H)
  - Billing Message – This bill is a reconsideration of a previously reviewed bill. Allowance amounts do not reflect previous payments.

### Issues

1. What is the correct MAR for the disputed services?
2. Is the requestor entitled to additional reimbursement?

### Findings

1. This dispute involves a Designated Doctor Impairment Rating (IR) evaluation, with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(j)(4), which states that “(C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (i) Musculoskeletal body areas are defined as follows: (I) **spine** and pelvis; (II) **upper extremities** and hands; and, (III) **lower extremities** (including feet). (ii) The MAR for musculoskeletal body areas shall be as follows... (II) If full physical evaluation, with range of motion, is performed: (-a-) **\$300 for the first musculoskeletal body area**; and (-b-) **\$150 for each additional musculoskeletal body area**. (D) ... (i) Non-musculoskeletal body areas are defined as follows: (I) **body systems**; (II) body structures (including skin); and, (III) mental and behavioral disorders. (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides... (v) **The MAR for the assignment of an IR in a non-musculoskeletal body area shall be \$150**” [emphasis added].

Review of the submitted documentation finds that the requestor performed impairment rating evaluations of the cervical, thoracic, and lumbar; right wrist and shoulder; right hip, left knee, and left ankle; and the head – cerebral concussion. The insurance carrier’s position statement indicates that they are placing the impairment rating of the head in the musculoskeletal category with the spine. However, the AMA Guides to the Evaluation of Permanent Impairment (fourth edition) places the head in the neurological systems category. For this reason, it is considered a body system in the non-musculoskeletal category.

Therefore, the correct MAR for the disputed services is \$1100.00. See the table below for a detailed analysis.

Examination	§134.204 Category	Reimbursement Amount
Maximum Medical Improvement		\$350.00
IR: Head (cerebral concussion)	Body systems	\$150.00
IR: Cervical spine	Spine & Pelvis	\$300.00
IR: Thoracic spine		
IR: Lumbar spine		
IR: Rt wrist	Upper Extremities	\$150.00
IR: Rt shoulder		
IR: Rt hip	Lower Extremities	\$150.00
IR: Lt knee		
IR: Lt ankle		
<b>Total MMI</b>		<b>\$350.00</b>
<b>Total IR</b>		<b>\$750.00</b>
<b>Total Exam</b>		<b>\$1,100.00</b>

2. Review of the submitted documentation finds that the allowable reimbursement for the designated doctor examination is \$1100.00. The insurance carrier reimbursed \$950.00. The requestor is entitled to an additional reimbursement of \$150.00.

## **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$150.00.

## ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

## **Authorized Signature**

_____	<u>Laurie Garnes</u>	<u>January 13, 2015</u>
Signature	Medical Fee Dispute Resolution Officer	Date

## ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**